STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint IN00118354. Complaint IN00118354-Substantiated. Federal/state deficiencies related to the allegations are cited at F157, F282, F309, and F514. Survey dates: November 26 & 27, 2012 Facility number: 011151 Provider number: 155794 AIM number: N/A Survey team: Diana Zgonc, RN Census bed type: SNF: 7 Residential: 23 Total: 30 Census payor type: Medicare: 3 Other:: 27 Total: 30 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Quality review completed on November 29, 2012 by Bev Faulkner, RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to ensure the physician was notified of vitals signs as ordered and notified of a medication error according to the facility policy for 1 of 3 residents	F0157	F. 157 **What corrective action will be taken by the facility? 1.** Resident is no longer in the community. **How will facility identify other residents having the potential to be affected by**	12/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reviewed for physician notification (Resident B). Findings include: A current facility policy, dated 11/1/12, and titled "Physician Notification" and provided by the Assistant Director of Nursing (ADON) indicated: "Policy Upon identification of a patient who has a change in condition or abnormal lab values, a licensed nurse will perform appropriate clinical observations and data collection and report to physician. ... Guideline for Physician Notification ... Medication Error, All episodes." The record for Resident B was reviewed on 11/26/12 at 10:20 A.M. Diagnoses for Resident B included but were not limited to mantel cell lymphoma, atrial fibrillation, acute renal failure, cardiomyopathy, right lower lobe pneumonia and MRSA (methicillin resistant staphylococcus aureus bactermia). The resident was admitted to the facility on 8/31/12. On admission the resident had physician's orders to receive Vancomycin 1.25 GM		**the same practice and what corrective action will be taken?** 2. Every resident within the skilled unit has the potential to be affected by the deficient practice. Review of current skilled resident's physician orders will be reviewed. **What measures will be put into place to ensure the deficient practice does not recur?** 3. All nurses have been in-serviced on utilizing the SBAR system for physician notification the first week of November with re-education on December 4, 2012. December 4 th in-service training incorporated the Senior Living Concepts guidelines for physician notification. Nurses will be held accountable to the guidelines through audits of nursing documentation. DON, ADON, or RN will review at least three new orders for physician and family notification. Nurse will identify on phone order form, whom they notified and their own initials in the space provided at base of order. DON, ADON, or RN will also monitor daily 24 hour report sheet to identify change of conditions and review documentation for notification accordingly. All in-servicing will be completed by 12/27/12. **How will the corrective action be monitored:** **4.** Results of the audits will be reviewed at monthly QA meetings for three months or until a pattern of compliance is established. **5.** Compliance Date: 12/27/12	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	every 24 hours by intravenous (IV) piggyback via the PICC (peripherally inserted central catheter) line at 10:00 P.M. A nurses note, dated 9/2/12 at 8:30 P.M., indicated the nurse could not get the resident's IV pump to work correctly. She attempted to call the pharmacy, but there was no answer. She also notified the DON and was told the facility would trouble shoot the IV pump in the morning. A nurses note, dated 9/3/12 at 12:00 P.M., indicated the Vancomycin had been administered. The record lacked documentation of what time the medication was actually administered. A nurses note, dated 9/4/12 at 2:00 P.M., indicated the Vancomycin order had been changed to 2:00 P.M. The record lacked documentation of the physician being notified of a medication error and the resident had not received his ordered Vancomycin on 9/2/12. A physician's telephone order, dated 9/16/12, indicated ... 7. vital signs every shift and to call the physician if the systolic blood pressure was less than 90. The "Vital Signs and Weight Record"			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated on 9/20/12 at 10:15 (no A.M. or P.M. designation) the resident had a blood pressure of 88/58. The record lacked documentation of physician notification for blood pressures as ordered. During an interview with the Director of Nursing (DON) on 11/26/12 at 4:30 P.M., physician notification for decreased blood pressures and the medication error were requested. During an interview with the DON on 11/27/12 at 8:45 A.M., she indicated no physician notification could be found for the decreased blood pressure or the medication error. This Federal Tag relates to Complaint IN00118354. 3.1-5(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview ,the facility failed to ensure the resident's vitals signs were monitored according to physician's orders and failed to ensure medications were given as ordered for 1 of 3 residents reviewed for physician's orders (Resident B). Findings include: The record for Resident B was reviewed on 11/26/12 at 10:20 A.M. Diagnoses for Resident B included, but were not limited to mantel cell lymphoma, atrial fibrillation, acute renal failure, cardiomyopathy, right lower lobe pneumonia and MRSA (methicillin resistant staphylococcus aureus bactermia). The resident was admitted to the facility on 8/31/12. On 9/16/12, a physician's telephone order indicated the residents VS (blood pressure, temperature, pulse and heart rate) should be monitored every shift and	F0282	F 282 **What corrective action will be taken by the facility?** 1. The resident no longer lives in this community. Licensed nurses will review care plans for each of the skilled residents. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken?** **2.** Every resident in the skilled unit has the potential to be affected by the deficient practice. Those residents with current orders for vital signs will all be reviewed. **What measures will be put into place to ensure the practice does not recur? 3.** New orders will be reflected on the resident care plan immediately or as soon as possible following the receipt of new orders. Nurse management will review new orders and placement of these on the care plans for two weeks. After two weeks if good compliance is achieved, the DON,ADON or RN will review one to two new orders weekly to determine placement on the care plan and nursing knowledge of care plan entry through question and response. New orders are reviewed daily,	12/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to call the physician if the systolic blood pressure falls below 90. The record lacked documentation of the VS monitoring on the following dates: 9/16/12 7a - 7p shift. No temperature, pulse or respirations 9/17/12 7p - 7a shift. No temperature, pulse or respirations 9/18/12 7a - 7p shift. No temperature, pulse or respirations 9/20/12 7a - 7p shift. No temperature and a blood pressure of 88/58, no physician notification On 9/30/12, a second physician's telephone order indicated the resident's VS should be monitored every shift and to call the physician for systolic blood pressure less than 90. The record lacked documentation of the VS monitoring on the following dates: 9/30/12 7p - 7a shift. No vital signs 10/1/12 7p - 7a shift. No vital signs 10/2/12 (shift not known). No vital signs 10/4/12 No vital signs for either shift 10/5/12 7a - 7p shift. No vital signs. On admission the resident had physician's orders to receive Vancomycin 1.25 GM every 24 hours by intravenous (IV) piggyback via the PICC (peripherally inserted central catheter) line at 10:00		M-F, during morning stand up meeting. **How will the corrective action be monitored:** **4.** Results of the audits will be reviewed at monthly QA meetings , for three months or until a pattern of compliance is established. 5. Compliance Date: December 27, 2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	P.M. A nurses note, dated 9/2/12 at 8:30 P.M., indicated the nurse could not get the resident's IV pump to work correctly. She attempted to call the pharmacy, but there was no answer. She also notified the DON and was told the facility would trouble shoot the IV pump in the morning. The resident did not receive the ordered Vancomycin on 9/2/12. The record lacked documentation of what time the medication was actually administered. During an interview on 11/26/12 at 4:30 P.M., with the DON, the missing vital signs were requested. During an interview on 11/27/12 at 8:45 A.M., with the DON she indicated none of the vital signs could be found and the resident did not receive the ordered Vancomycin on 9/2/12. This Federal Tag relates to Complaint IN00118354. 3.1-35(g)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure nurses were educated on peripherally inserted central catheters (PICC) line care and failed to ensure daily PICC line care was completed for 1 of 1 resident reviewed for PICC line care resulting in a deep vein thrombosis (blood clot) of the left brachial (arm) vein. (Resident B). Findings include: A current facility policy, dated 1/15/14 and revised 7/1/12, titled "Peripheral Catheter Flushing" and provided by the Director of Nursing (DON) on 11/26/12 at 2:35 P.M., indicated: "To be Performed By: Licensed nurses according to state law and facility policy. The nurse shall be competent in the safe delivery of infusion therapy with her or his scope of practice. The nurse shall be accountable for attaining and maintaining competence with infusion therapy within her or his scope of practice. Considerations:	F0309	F 309 **What corrective action will be taken by the facility?** 1. The resident no longer lives in this community. **How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? 2.** Every resident on the skilled unit with a PICC line has the potential to be affected by the deficient practice. The facility currently has no residents with PICC lines. **What measures will be put into place to ensure the deficient practice does not recur? 3.** Each nurse is being trained or re-trained on Central Line Care and Maintenance. Training will entail classroom and return demonstration. Residents requiring PICC line care will not be admitted until training complete. All nurses hired after compliance date will be trained utilizing training DVD prior to assignment on the floor. DON , ADON or RN will observe return demonstration by nurse. Once PICC line admissions begin, Omnicare IV physician order sheets will be utilized, identifying	12/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. Specific flush orders must be documented ... ... 3. Flushing is performed to ensure and maintain catheter patency ... The record for Resident B was reviewed on 11/26/12 at 10:20 A.M. Diagnoses for Resident B included but were not limited to mantel cell lymphoma, atrial fibrillation, acute renal failure, cardiomyopathy, right lower lobe pneumonia and MRSA (methicillin resistant staphylococcus aureus bactermia). The resident was admitted to the facility on 8/31/12 with a left upper arm PICC line. Discharge instructions from the hospital on 8/31/12 indicated additional instructions, routine PICC line care. Resident B had medication orders for Vancomycin 1.25 GM every 24 hours to be infused thru the PICC line and to flush the PICC with 10 milliliters of normal saline before and after administration of the antibiotic. Discontinue the use of Vancomycin after the 9/21/12 dose. Review of the resident medical record lacked any specific orders for flushing the		all areas of attention for the proper care and maintenance of PICC /central line. Flushing orders read as follows: Use SASH technique or SAS (Use saline only for valved catheters all ports, PICCs and Central lines.) Continuous infusion - No flushing needed. Intermittent Meds: Non-Valved, SASH 10 ml Normal Saline before Med, 10ml normal saline after Med then 5 ml Heparin 10units/ml. Valved Catheter (SAS) 10 ml Normal Saline before Med, 10 ml Normal Saline after Med. Minimum flush for unused Lumens: PICC non-valved q 12 hours each lumen 10ml Normal Saline then 5 ml Heparin 10units/ml. PICC valved catheter Q week flush each lumen with 10 ml Normal Saline. Clarification of which type, valved or non-valved will be received from the hospital prior to admission of new resident. Order sheet will be reviewed with admitting physician for clarification of orders. All steps necessary for the proper care and maintenance of the PICC/central line will be placed on the MAR for q shift review and performance. **How will the corrective action be monitored: 4.** Each resident admitted with PICC/Central Line will have full audit, by the DON, ADON, or RN of physician orders, MARs and Care Plan to ensure proper clarification and implementation of physician orders. Audits will be completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resident's PICC line when not in use. Review of the resident's Medication Administration Record (MAR) indicated the Vancomycin was discontinued on 9/21/12 as ordered. The MAR lacked any documentation of PICC line care, including flushing the PICC line on 9/22/12, 9/23/12, 9/25/12, 9/26/12. The resident received a one time order for Vancomycin on 9/27/12 and the medications and flushes administered as ordered. The resident received a one time order of Vancomycin on 9/28/12 and the medications and flushes administered as ordered. The MAR lacked any documentation of PICC line care, including flushing the PICC line on 9/29/12, 9/30/12, 10/2/12, 10/3/12, 10/4/12 and 10/5/12. Blood draws were ordered on 9/24/12 and 10/1/12 and the PICC line was flushed at that time. A nurses note, dated 10/5/12 at 4:00 A.M., indicated the resident was NPO (nothing by mouth) for his appointment this A.M.		within 48 hours of admission. Results of the audits will be reported at monthly QA meeting for three months or until QA committee determines a pattern of compliance has been established. **5.** Compliance date: December 27, 2012.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A hospital critical care consult note, dated 10/5/12 at 13:46 (1:46 p.m.) indicated "... the PICC line has been difficult to dislodge ..." A hospital emergency room note, dated 10/5/12 at 14:59 (2:59 p.m.), indicated "when they attempted to remove the PICC line the resident became symptomatic ..." A hospital Staff Initial Consult, dated 10/5/12 at 23:59 (11:59 p.m.), indicated "... A Doppler (determine blood flow through arteries and veins) of the area shows a totally occluding acute DVT (deep vein thrombosis) of the left brachial vein." During an interview with MD #1 on 11/26/12 at 10:05 A.M., he indicated the discharge instructions from the hospital would be routine PICC line care and would not be specific. They would leave that up to the facility physician to specify what that would be. He also indicated routine PICC line care would include proper dressing change technique, flushes and when it would be appropriate to discontinue use of the PICC line. During an interview with the DON on 11/27/12 at 10:30 A.M., she indicated there was no documentation of any education or inservicing the nurses for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	residents who require PICC line care. She also indicated some of the nurses were not IV certified and the nurses could not remember if there was an order to flush the PICC when not being used. During an interview with the Administrator on 11/27/12 at 3:00 P.M., she indicated no residents with PICC lines would be admitted to the facility until all the nurses had gone to IV training. During an interview with the facility's MD on 11/27/12 at 3:16 P.M., he indicated the PICC line should be flushed at least 2 or 3 times a day when not being used. If the discharge instructions from the hospital did not include specific flush orders then it would be up to the nurse to call and get clarification. "If I were writing the order it would be a minimum of 2 times a day if the PICC line is not in use." He also indicated during the interview that he had been called by the emergency department at the hospital and was informed the PICC line was clotted off (not patent). This Federal Tag relates to Complaint IN00118354. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to ensure the documentation in the resident's clinical record was accurate for 1 of 3 resident's reviewed for accurate records (Resident B). Findings include: The record for Resident B was reviewed on 11/26/12 at 10:20 A.M. Diagnoses for Resident B included but were not limited to mantel cell lymphoma, atrial fibrillation, acute renal failure, cardiomyopathy, right lower lobe pneumonia and MRSA (methicillin resistant staphylococcus aureus bactermia). A nurses note, dated 9/2/12 at 8:30 P.M.,	F0514	F 514 **What corrective action will be taken by the facility?** **1.** The resident is no longer in the community. **How will the facility identify other residents having he potential to be affected by the same practice and what corrective action will be taken?** **2.** Every resident has the potential to be affected by the deficient practice. Residents on the skilled unit with orders for vital signs have been reviewed for compliance. **What measures will be put into place to ensure the practice does not recur?** **3.** Each nurse will be in-serviced on the timeliness of med passing and physician notification. In the event the equipment does not work, physician will be notified to allow for alternate plan of care in the interim. Senior Living Community Unusual Occurrence	12/27/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155794	A. BUILDING 00 B. WING	11/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN 46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the nurse could not get the resident's IV pump to work correctly. She attempted to call the pharmacy, but there was no answer. She also notified the DON and was told the facility would trouble shoot the IV pump in the morning. The resident did not receive the ordered Vancomycin on 9/2/12. Review of the medication administration record (MAR) for 9/2/12 indicated the resident received the ordered dose of Vancomycin on 9/2/12. During an interview with the DON on 11/27/12 at 8:45 A.M., she indicated the resident did not receive the ordered Vancomycin on 9/2/12, it was 6 hours late. This Federal Tag relates to Complaint IN00118354. 3.1-50(a)(2)		Report will be completed in the event that medication cannot be given for whatever reason, equipment failure or delivery issues. Notification of physician and family will be documented on the form at time of report. DON, ADON or RN will audit three residents weekly for timeliness of medication pass for one month, then three times monthly and reported to QA committee monthly meetings. **How will the corrective action be monitored:** **4.** DON,ADON or RN will report finding from audits to the monthly QA meeting for three months until QA committee has determined a pattern of compliance is established. **5.** Compliance date: December 27, 2012	